

# Getting Healthcare in Ireland Conference

*Croke Park Conference Centre*

*15<sup>th</sup> September 2018*

## Accessing High-Quality Hospital Care

Dr Una Geary,  
Director of Quality and Safety Improvement  
St James's Hospital, Dublin

*All views expressed are my own and do not represent any organisation with which I am or have been associated*

# Questions and Concepts



- Can we assure equitable access to consistently high standards of acute hospital care?
- What is high-quality healthcare in an acute hospital?
- What not to do
- What to do more of

**Providing equitable access to  
safe, high-quality acute hospital  
care is a significant challenge in  
our health service**

What is 'quality' for acute hospitals?

# National Standards for Safer Better Healthcare, 2012



Service user at the centre of a culture of quality and safety

- Safe care
- Effective care
- Person-centred care
- Health & wellbeing
- Governance, leadership & management
- Workforce
- Use of resources
- Use of information

# Quality

- The degree to which a system of production meets, or exceeds the needs and desires of the people it serves.’<sup>1</sup>
- The dimensions of quality in healthcare are:
  - safe,
  - timely,
  - effective,
  - equitable,
  - efficient and patient-centred.<sup>2</sup>
- Defined from the patient’s perspective

*A promise to learn— a commitment to act. Improving the Safety of Patients in England. National Advisory Group on the Safety of Patients in England. August 2013.*

*Crossing the Quality Chasm – a new health system for the 21<sup>st</sup> Century in 2001.*

# National Patient Experience Survey



## Admission:

- 54% said they had a very good experience, with 30% saying they had a good experience.
- 16% said they had a fair to poor experience, which represents a very considerable group of patients.

## Ward-based care:

- 85% of patients had a very good or good experience of 'care on the ward'.

Research indicates that better patient care experiences are associated with higher levels of adherence to recommended prevention and treatment processes, better clinical outcomes, better patient safety within hospitals, and less health care utilization.

# Population Outcomes



- Most Irish people report being in good health, although there are disparities by income group
- Life expectancy at birth in Ireland was 81.5 years in 2015, up from 76.6 years in 2000 and slightly above the EU average.
- Amenable mortality is lower than the EU average but **far from best performing countries**
- Health spending per capita in Ireland is higher than in most other EU countries
- Ireland struggled to maintain levels of health services throughout the financial crisis.

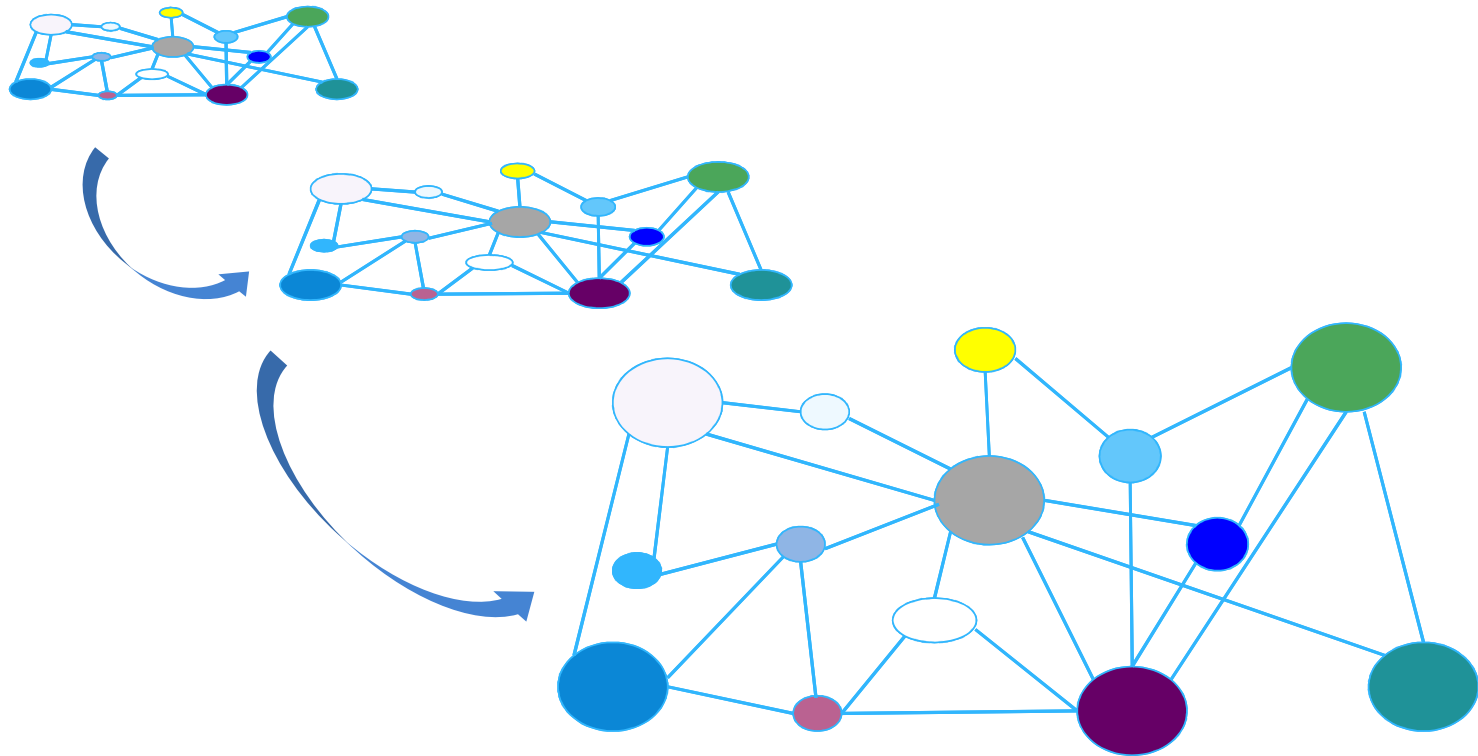


# Key Concepts

# Quality is 'made' at the clinical frontline

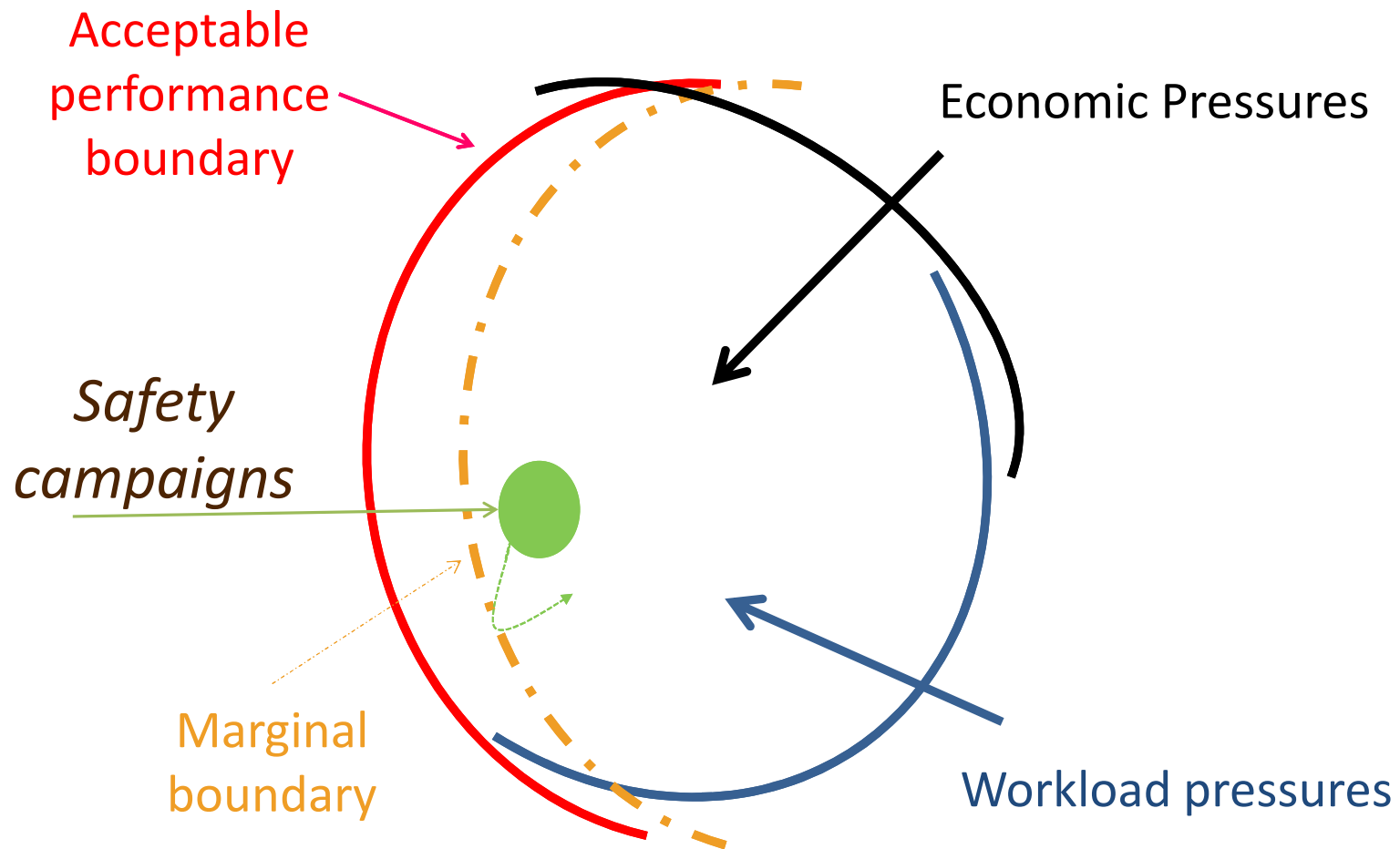
All other elements of the system exist to support quality  
that is made 'where patients and providers meet'

# Complex Socio-Technical Systems in a System of Systems



- Dynamic - adaptive to internal and external change
- Relationships, contexts and cultures
- Multiple perspectives and sense-making
- Knowledge capture, information-flows and feedback loops
- Processes that evolved in healthcare

# Rasmussen's Dynamic Model of Safety & Going Solid



# How to deliver safer, better hospital care

# International perspective



- Patient harm occurs in all health systems
  - Inherent risk
  - Human endeavour
  - Complex adaptive socio-technical systems
- Slow international progress in patient safety
- More resources alone won't deliver better systems outcomes

Framework for  
Improving Quality  
in our Health Service

Part 1:  
Introducing the Framework

Quality Improvement Division,  
April 2016.  
ISBN: 978-1-78602-014-7

HSE  
Halhinneonacht na Seirbhíse Sláinte  
Health Service Executive



# Berwick Report – Improving the safety of patients in England, 2011



- Staff are not to blame .....it is the systems, procedures, conditions, environment and constraints.....
- Incorrect priorities do damage.....central focus must always be on patients.
- Fear is toxic to both safety and improvement



# Committee on the Future of Healthcare

## Sláintecare Report



**Patient safety is fundamental to the delivery of quality healthcare.**

**The public must have confidence in the safety of our health services.**

- Strong governance structures
- Senior clinical leadership ..... to ensure this happens
- Clinical governance legislation
- Organisations are responsible and accountable for:
  - Continuously improving quality
  - Safeguarding standards of care
  - Ensuring best clinical outcomes
  - Actively involving patients in planning, providing and evaluation of their care

# Committee on the Future of Healthcare – Sláintecare Report

- Clinical governance ..... requires *commitment ... organisational culture that is conducive to the provision of high quality and safe care for patients and clients ..... characterised by a shared passion for quality, openness, respect, support and fairness, no blame or retribution .....*
- *Procedures and practices are in place which ensure **high standards of clinical performance, clinical risk management, clinical audit, ongoing professional development and well developed processes to investigate, take action and manage adverse clinical events .....***
- *Effective teamwork, managing health to ensure clinical efficiency and effectiveness*

Efforts and courage are not enough  
without purpose and direction

JF Kennedy

Prioritise the priorities

# Priority Thickets

“The proliferation of externally set priorities and the number of different agencies and actors created what we termed ‘**priority thickets**’ – dense patches of **overlapping or disjointed goals** that commanded very substantial attention and resources, but did not necessarily provide **clear direction** or facilitate the development of clear goals, internally coherent visions or strategies linked to local priorities”

“**targets, standards, incentives and measures seemed to crowd in** from multiple external sources; that the same information was required many times in different formats ..... costly and distracting”

**Impact:** “displays of compliance”, defensive & reactive activity, frustration

Mary-Dixon Woods et al.

# Use Quantitative Targets with Caution

*Such goals do have an important role enroute to progress, but should never displace the primary goal of better care - Berwick*

# Targets and Measures

“... the number of measures threatens to **shift resources from improving quality to cover a plethora of quality performance metrics that may have a limited impact.**”

*Meyer et al BMJ Qual Saf 2012;21:966–968*

- Perspectives on the data – manager, clinician, patient?<sup>1</sup>
- Measures that are convenient rather than measures that matter
- What isn't measured may be ignored

*1. Neuhauser, Provost, Bergman. BMJ Qual Saf 2011;20(Suppl 1):i36ei4*

“.... the dangers of espousing quality as a goal strategically without considering how to operationalise it properly ..... have been evident in spectacular failures in standards of care when **the much more easily quantifiable measures—money and activity— were the true priority for managers of the system.**”

*Donaldson and Darzi BMJ Quality and Safety, August 2012*

# Exnovation for Innovation



The organisation must discard existing practice associated with a previously implemented innovation, thereby allowing the adoption of a new innovation, where the life cycle starts again.

*Kimberly J (1981). Managerial Innovation. In Nystrom, P & Starbuck, W. (Eds), 'Handbook of Organizational Design-Volume 1. New York: Oxford University Press. pp 84-104*

***Please tell me what to stop doing***



*“No other industry has more potential to free up resources from non-value-added and inefficient production practices than health care and no other industry has greater potential to use its resources to add value, promote health and relieve suffering. “*

Through the eyes of the workforce – creating joy, meaning and safer health care  
*Report of the roundtable on Joy and Meaning in Work and Workforce Safety 2013*  
*The Lucian Leape Institute. Boston, MA: National Patient Safety Foundation; 2013.*

Available at <https://psnet.ahrq.gov/resources/resource/25832/through-the-eyes-of-the-workforce-creating-joy-meaning-and-safer-health-care>

# Increasing complexity is our reality

- Pace of healthcare technology innovation
- Information age
- Aging population
- Expectations
- Societal change

A system is resilient if it can adjust its functioning prior to, during, or following events (changes, disturbances, and opportunities), and thereby sustain required operations under both expected and unexpected conditions.<sup>1</sup>

*Respond - Monitor - Learn – Anticipate*

# Healthcare provider – sustained system pressures

*Intelligent Kindness, reforming the culture of healthcare, John Ballatt  
and Penelope Campling RCPsych Publications, 2011*

# Quality is Personal

---

# **hello** my name is...

# Ideas for safer, better healthcare



Prune ....

- Priorities
- Targets and measures
  
- Tackle the urgent big problems
  
- Help services learn to adapt
  
- Avoid fear and blame, promote trust and balanced accountability – it's personal!